Nottingham City Health Scrutiny Committee

Briefing on the White Paper
Integration and Innovation: working together to improve health and social care for all

Introduction

1. This paper provides Nottingham City Health Scrutiny Committee with an overview of the Department of Health and Social Care's White Paper entitled *Integration and Innovation: working together to improve health and social care for all*.

2. This paper also confirms opportunities, arising from this White paper, for local citizens.

Background

3. Health and care systems need to continually develop and evolve to remain fit for purpose in an ever changing landscape. As the NHS and Social Care services in England look to recover from the Covid-19 global pandemic, national policy centres on Integrated Care Systems (ICSs) as providing the best route to improving population health and wellbeing, quality of service provision and achieving the most effective use of resources.

4. An ICS brings together citizens, NHS, Local Authority and wider partners to meet the health and care needs in an area, to co-ordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

5. Integrated care is not new but rather has a long history. Over recent years, Nottingham City residents have benefitted from tangible improvements brought about by an Integrated Care Pioneer programme; a Vanguard focused on Support to Care Homes; and collective endeavours across the Nottingham and Nottinghamshire ICS in responding to Covid-19.

6. To date, the NHS and Social Care system has not been fully configured to accommodate the development of ICSs. The White Paper aims to go some way to addressing this.

Working Together to Integrate Care

7. Subject to legislation, ICSs will be established on a statutory footing as ICS Bodies across England from 1st April 2022, bringing partners together to support integration of health and social care.

8. Strengthened decision making and accountability for system performance will be embedded into the NHS accountability structure through an NHS ICS Board and ICS Health and Care Partnership. This dual structure recognises that there are two forms of integration which will be underpinned by legislation: integration within the NHS to remove some of the cumbersome barriers to collaboration and to make working together across the NHS an organising principle; and the integration between the NHS and others, principally local authorities, to deliver improved outcomes to health and wellbeing for local people. The approach is framed by:

    - The importance of shared purpose within places and systems;
    - The recognition of variation – some of it warranted – of form and in the potential balance of responsibilities between places and the systems they are part of;
    - The reality of differential accountabilities, including the responsibility of Local Authorities to their elected members and the need for NHS bodies to be able to account for NHS spend and healthcare delivery and outcomes.

9. The NHS ICS Board (including representatives from NHS bodies and Local Authorities) will be responsible for the day-to-day running of the ICS, NHS planning and allocation decisions merging some of the current ICS and CCG functions:

    - Developing a plan to meet the health needs of the population within their defined geography;
    - Developing a capital plan for the NHS providers within their health geography;
    - Securing the provision of health services to meet the needs of the system population.

10. The NHS ICS Board will, as a minimum, include a chair, a chief executive officer, and representatives from NHS Trusts, General Practice, and Local Authorities, non-executives and others determined locally. ICSs will also need to ensure they have appropriate clinical advice when making decisions.

11. The ICS Health and Care Partnership will bring together the NHS, local government and wider partners such as those in the voluntary sector. This Partnership will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system – the ICS NHS Body and Local Authorities will have to have regard to this plan when making decisions.

12. Members of the ICS Health and Care Partnership could be drawn from a number of sources including Health and Wellbeing Boards (HWBs) within the system, partner organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers). Local areas can appoint members and delegate functions as they think appropriate.

13. The ICS will also have to work closely with local Health and Wellbeing Boards as they have the experience as ‘Place-based’ planners, and the ICS NHS Body will be required to have regard to the Joint Strategic Needs assessments (JSNAs) and Joint Health and Wellbeing Strategies that are being produced at Health and Wellbeing Board level (and vice-versa).

14. Creation of statutory ICS NHS Bodies will allow NHS England to have an explicit power to set a financial allocation or other financial objectives at a system level. There will be a duty placed on the ICS NHS Body to meet system financial objectives supplemented by a new duty to compel providers to have regard to the system financial objectives. The ICS NHS Body will not have the power to direct providers, and providers’ relationships with the Care Quality Commission will remain unchanged.

15. The allocative functions of CCGs will be held by the ICS NHS Body. The ICS NHS Body will take on the commissioning functions of the CCGs and some of those of NHS England within its boundaries, as well as CCGs’ responsibilities in relation to Oversight and Scrutiny Committees. The Chief Executive will become the Accounting Officer for the NHS money allocated to the NHS ICS Body.

16. A duty to collaborate will be introduced for NHS and Local Authorities to support collaboration across the health and care system and a triple aim duty placed on health bodies, including ICSs covering: better health and wellbeing for everyone; better quality of health services for all individuals; and sustainable use of NHS resources.

17. Barriers to integration will be removed through making provisions for joint committees, collaborative commissioning approaches and guidance on joint appointments. The legislation will also ensure more effective data sharing across the health and care system, which is critical to effective integration, and will enable the digital transformation of care pathways.

18. There will be increasing collaboration between ICSs and with NHS England on commissioning to make decisions, pool funds and facilitate services to be arranged for their combined populations. This will include primary care services (e.g. dentistry, community optometry, pharmaceutical services) as well as public health and specialised services.

19. Requirements for Place will not be set in legislation with the recognition that Places vary by population and geography. However, there is an expectation that the statutory ICSs’ will also work to support places within its boundaries to integrate services and improve outcomes – recognising that different places will be at different stages of development and face different issues. Health and Wellbeing Boards will remain in place and will continue to have a role at Place level.

20. A key responsibility for an ICS will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector. Place level

commissioning within an integrated care system will most likely align geographically to a local authority boundary, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities.

21. To support patient choice, section 75 of the Health and Social Care Act 2012 (including the Procurement, Patient Choice and Competition Regulations 2013) will be repealed and replaced with a new procurement regime, alongside a bolstered process for Any Qualified Provider (AQP).

Reducing Bureaucracy

22. The White Paper sets out significant changes to procurement with an end to mandatory competitive procurements, instead only tendering for healthcare and public health services when there is potential to lead to better outcomes for patients.

23. The Competition Market Authority (CMA) will no longer be involved in NHS oversight. Instead there will be the creation of a bespoke health services provider selection regime to give greater flexibility to commissioners in how they arrange services.

24. Changes to the national Tariff (the NHS financial framework) will allow more flexibility and support system approaches. In addition, the White Paper sets out new powers to be given to the Secretary of State to create new Trusts for the purpose of providing integrated care.

Improving Accountability and Enhancing Public Confidence

25. A newly merged national NHS body formally merging Monitor and the Trust Development Authority (NHS Improvement) into NHSE. Complemented by enhanced powers of direction for the government to support greater collaboration, information sharing and aligned responsibility and accountability.

26. As an ICS becomes established there is an expectation that it will have greater autonomy and hold a greater level of responsibility enabled by a more flexible mandate for NHS England. This new mandate will set direction over a longer term and in a more strategic way than currently permitted in an annual cycle. NHS England's capital and revenue resource limits will continue to be set within annual financial directions, which are routinely published and will now be set before Parliament.

27. There will be new powers for the Secretary of State for Health and Social Care over the NHS and other arm's-length bodies (ALBs). Under the proposals, the Secretary of State will be able to intervene in service reconfiguration changes at any point without need for a referral from a local authority. The Department of Health and Social Care will also be able to reconfigure and transfer the functions of arm's-length bodies (including closing them down) without primary legislation.

28. Certain new duties on the Secretary of State will also be introduced. This will include a statutory duty to publish a report in each parliament on workforce planning responsibilities across primary, secondary and community care, as well as sections of the workforce shared between health and social care.

Additional Measures

29. Reforms to social care, public health and mental health will be dealt with outside the Health and Care Bill addressed in the White Paper, with some minor exceptions (as set out below) and proposals will be published later this year.

Social Care

30. A new assurance framework will be introduced together with powers to collect data from providers in social care. An improved level of accountability will be introduced within social care, with a new assurance framework allowing greater oversight of Local Authority delivery of care, and improved data collection to better understand capacity and risk in the social care system (including for self-funders).

31. Powers will be included enabling the Secretary of State to make emergency payments directly to all social care providers when needed to prevent instability in care.

32. There will be a defined role for social care within the ICS NHS Board and guidance on how ICS Health and Care Partnerships can be used to align operating practices and culture with the legislative framework to ensure ICSs' deliver for the Adult Social Care sector.

33. A new legal framework for Discharge to Assess will be included enabling person-centred models of hospital discharge and greater flexibility to when assessments for care can be made. Discharge to Assess will not change the thresholds of eligibility for Continuing Health Care (CHC) or support through the Care Act or increase financial burdens on Local Authorities. The system of discharge notices, and associated financial penalties, will no longer be required.

34. The White Paper includes a new standalone legal basis for the Better Care Fund, separate from the NHS Mandate setting process, removing the need for annual planning cycles. It also includes a new duty for the Care Quality Commission (CQC) to assess local authorities' delivery of adult social care services, and a power for the Secretary of State to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their responsibilities.

Public Health

35. Alongside the Government's proposals for the future design of the public health system, including the creation of the National Institute for Health Protection (NIHP) and the closure of Public Health England (PHE), the White Paper sets out new measures to make it easier for the Secretary of State to direct NHS England to take on specific public health functions (section 7a services).

36. The White Paper details the introduction of new public health requirements conveying a new power on ministers to alter certain food labelling requirements, in addition to already announced further restrictions on the advertising of high fat, salt and sugar foods including before the 9pm watershed; and the responsibility for the process to directly introduce, vary or terminate fluoridation of water to be moved from Local Authorities to the Secretary of State for Health and Social Care.

Quality and Safety

37. The White Paper details:

    - Enshrining the Healthcare Safety Investigations Branch (HSSIB) into law as a statutory Body to reduce risk and improve safety;
    - Enabling improvements to the current regulatory landscape for healthcare professionals with a view to reducing the number of regulators following further work;
    - Establishing a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths that do not involve a coroner, to increase transparency for the bereaved;
    - Allowing the Medicines and Healthcare products Regulatory Agency (MHRA) to develop and maintain publicly funded and operated medicine registries in order to provide patients and prescribers, as well as regulators and the NHS, with the information they need to make evidence-based decisions;
    - Bringing forward measures to enable the Secretary of State to set requirements in relation to hospital food;
    - Powers to implement comprehensive reciprocal healthcare agreements with countries outside the EEA and Switzerland to support the health of citizens when they travel abroad, subject to bilateral agreements.

Opportunities for Local Citizens

38. The Nottingham and Nottinghamshire ICS is working to the shared purpose of every citizen enjoying their best possible health and wellbeing.

39. The ICS creates the conditions in which health and care professionals – working at neighbourhood, place and whole system level – are able to come together maximising the use of our energies and resources; seeking out and

implementing the types of change that deliver enduring improvements in population health and wellbeing across:

- Primary and secondary care;
- Physical and mental health services; and
- Health, social care and wider public and community services.

40. To date, the NHS and Social Care system has not been fully configured to accommodate the development of ICSs. Policy, delivery and assurance mechanisms have not been fully aligned, which has resulted in barriers to improvement.

41. The removal of many barriers, as proposed in the White Paper, provides renewed impetus for collaborative working. Whilst the move to put ICSs onto a statutory footing from April 2022, subject to legislation, is a step forward, recognition is given to the fact that structural change alone is no guarantee of success in bringing about a high performing system that is agile, adaptive and therefore best able to serve its population needs.

42. The local health and care system therefore continues to build on work to date, including learning from joint working in response to Covid19, to ensure maximum benefit for the population served from integrated care.

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